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Supreme Court, U.S.
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No. 09-80

IN THE

Supreme Court of the United States

GEORGE SCHOEDINGER M.D.; SIGNATURE HEALTH SERVICES, INC., PETITIONERS

v.

UNITED HEALTHCARE OF THE MIDWEST, INC.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

A claim for a civil violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961 – 1968 ("civil RICO") predicated on mail fraud was dismissed by the United States District Court for the Eastern District of Missouri on the basis that Petitioners, health care providers, did not rely upon the false and misleading explanation of benefit forms (EOBs) generated by defendant, a health care insurer, which used the fraud to improperly process and underpay for health care services. Subsequently, this Court handed down its decision in *Bridge v. Phoenix Bond & Indemnity Co.*, which held that "a plaintiff asserting a RICO claim predicated on mail fraud need not show . . . that it relied on the defendant's alleged misrepresentations." 128 S.Ct. 2131, 2145, 553 U.S. --- (2008). Thereafter, the United States Circuit Court for the Eighth Circuit declined to reverse the judgment of the District Court. The decision of the Eighth Circuit condones the systematic, pervasive, and wanton practices of health care insurers in improperly processing claims for services provided to patients and will curtail future causes of action by other health care providers seeking proper reimbursement for services. The questions presented are:

I. Whether the Circuit Court failed to follow the rule of law enunciated in *Bridge v. Phoenix Bond & Indemnity Co.* and erred in affirming the dismissal of the civil RICO claim for the stated reason that Petitioners did not rely upon the misrepresentations of Defendant.

II. Whether the Circuit Court erred in finding that the EOBs were "truthful disclosures" when the District Court found that the EOBs were false,

misleading, and a result of Defendant's wanton refusal to correct its improper practices.

RULE 29.6

Petitioner, Signature Health Services, Inc., pursuant to Rule 29.6 states that it is a privately held company. There is no publicly held corporation that owns any of the company's stock.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

RULE 29.6 iii

TABLE OF AUTHORITIES v

OPINIONS BELOW 1

JURISDICTION 2

RELEVANT PROVISIONS INVOLVED 2

STATEMENT 5

REASONS FOR GRANTING THE PETITION 8

CONCLUSION 21

APPENDIX

Circuit Court Opinion 1a
District Court Judgment 15a
District Court Memorandum Opinion 16a
District Court Memorandum and Order 31a
District Court Memorandum and Order 56a
Order Denying Rehearing 59a

TABLE OF AUTHORITIES

Page

CASES

APPLETREE SQUARE I, LTD. PARTNERSHIP v. W.R. GRACE & CO., 29 F.3D 1283 (8TH CIR. 1994) 14
BRIDGE v. PHOENIX BOND & INDEM. CO., 128 S.CT. 2131, 170 L.ED.2D 1012, 553 U.S. --- (2008) 12, 13
BROWN v. CASSENS TRANSPORT CO., 546 F.3D 347 (6TH CIR. 2008) 13
CARPENTER v. UNITED STATES, 484 U.S. 19, 108 S.CT. 316, 98 L.ED.2D 275 (1987) 15
CHAZ CONCRETE CO., LLC v. CODELL, 545 F.3D 407 (6TH CIR. 2008) 13
GRANGE MUTUAL CASUALTY CO. v. MACK, 290 FED. APPX. 832 (6TH CIR. 2008) 13
K.C.1986 LTD. PARTNERSHIP v. READE MFG., 472 F.3D 1009 (8TH CIR. 2007) 17
LINDSEY v. DAYTON-HUDSON CORP., 592 F.2D 1118 (10TH CIR. 1979) 17
METZGER v. UNUM LIFE INS. CO. OF AMERICA, 476 F.3D 1161 (10 CIR. 2007) 17
NEDER v. UNITED STATES, 527 U.S. 1, 119 S.CT. 1827, 144 L.ED.2D 35 (1999) 11
PERSYN v. UNITED STATES, 935 F.2D 69 (5TH CIR. 1991) 17
REINHOLDSON v. MINNESOTA, 346 F.3D 847 (8TH CIR. 2003) 17
UNITED STATES v. STATE OF ARK., 791 F.2D 1573 (8TH CIR. 1986) 17

STATUTES

18 U.S.C. § 1341 ..... 2, 11
18 U.S.C. § 1343 3
28 U.S.C. § 1254(1) 2
42 U.S.C. § 5122 3
Mo. Rev. Stat. § 376.383 13

RULES

Fed. R. Civ. P. 52(c) 4, 15
Fed. R. Civ. P. 54(b) 4, 17

Petitioners George Schoedinger, M.D. and Signature Health Services, Inc. respectfully petition this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the Eighth Circuit is reported at 557 F.3d 872 and is reproduced at page 1a of the Appendix to this Petition ("App."). The unreported order of the United States Circuit Court for the Eighth Circuit denying Petitioners' Petition for Rehearing En Banc is reproduced at App. 59a. The orders and judgment of the District Court from which appeal was taken are reproduced as follows:

- The unreported Judgment of August 31, 2007 is reproduced at App. 15a;
- The order of the District Court on August 28, 2007, reported at 2007 WL 2462681, E.D.Mo. (No. 4:07-CV-00664 SNL), is reproduced at App. 16a;
- The order of the District Court on November 6, 2006, reported at 2006 WL 3803935, 40 Employee Benefits Cas. 2072, E.D.Mo. (No. 4:07-CV-00664 SNL), is reproduced at App. 31a; and
- The order of the District Court on May 22, 2006, 2006 WL 1391383, RICO Bus.Disp.Guide 11,078, E.D.Mo. (No. 4:07-CV-00664 SNL), is reproduced at App. 56a.

JURISDICTION

The judgment of the Eighth Circuit was entered on March 5, 2009. App. 1a. That Court denied a timely filed Petition for Rehearing En Banc on April 17, 2009. App. 59a. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

RELEVANT PROVISIONS INVOLVED

18 U.S.C. § 1341.

> Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, or to sell, dispose of, loan, exchange, alter, give away, distribute, supply, or furnish or procure for unlawful use any counterfeit or spurious coin, obligation, security, or other article, or anything represented to be or intimated or held out to be such counterfeit or spurious article, for the purpose of executing such scheme or artifice or attempting so to do, places in any post office or authorized depository for mail matter, any matter or thing whatever to be sent or delivered by the Postal Service, or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier, or takes or receives therefrom, any such matter or thing, or knowingly causes to be delivered by mail or such carrier according to the direction thereon, or at the place at which it is directed to be delivered by the person to whom it is addressed, any such

matter or thing, shall be fined under this title or imprisoned not more than 20 years, or both. If the violation occurs in relation to, or involving any benefit authorized, transported, transmitted, transferred, disbursed, or paid in connection with, a presidentially declared major disaster or emergency (as those terms are defined in section 102 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122)), or affects a financial institution, such person shall be fined not more than $1,000,000 or imprisoned not more than 30 years, or both.

18 U.S.C. § 1343.

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined under this title or imprisoned not more than 20 years, or both. If the violation occurs in relation to, or involving any benefit authorized, transported, transmitted, transferred, disbursed, or paid in connection with, a presidentially declared major disaster or emergency (as those terms are defined in section 102 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5122)), or affects a financial institution, such person shall be

fined not more than $1,000,000 or imprisoned not more than 30 years, or both.

Fed. R. of Civ. Proc. 52(c)

If a party has been fully heard on an issue during a nonjury trial and the court finds against the party on that issue, the court may enter judgment against the party on a claim or defense that, under the controlling law, can be maintained or defeated only with a favorable finding on that issue. The court may, however, decline to render any judgment until the close of the evidence. A judgment on partial findings must be supported by findings of fact and conclusions of law as required by Rule 52(a).

Fed. R. of Civ. Proc. 54(b)

When an action presents more than one claim for relief — whether as a claim, counterclaim, crossclaim, or third-party claim — or when multiple parties are involved, the court may direct entry of a final judgment as to one or more, but fewer than all, claims or parties only if the court expressly determines that there is no just reason for delay. Otherwise, any order or other decision, however designated, that adjudicates fewer than all the claims or the rights and liabilities of fewer than all the parties does not end the action as to any of the claims or parties and may be revised at any time before the entry of a judgment adjudicating all the claims and all the parties' rights and liabilities.

STATEMENT

Petitioners are health care providers which have been persistently denied monies owed to them by Defendant United Healthcare of the Midwest, Inc. ("Defendant" or "United") for healthcare claims which were wantonly and improperly processed by the system implemented by United. Such improper processing was concealed by the misstatements of United on the EOBs it submitted to Signature.

United implemented a computer system which was (a) designed to improperly process the healthcare reimbursement codes submitted by Petitioners to Defendant for reimbursement and (b) mislead the healthcare provider through the use of misstatements on United's EOBs. The District Court found that United engaged in improper "down coding" (reading certain healthcare reimbursement codes as requests for reimbursement for a less expensive service) and improper "bundling" or "grouping" (combining certain codes together as if they were one procedure). App. 36a, 37a. In addition, the District Court found that United persistently and improperly reduced Dr. Schoedinger's rates, as if he were an in-network provider. App. 37a. As an out-of-network provider, Dr. Schoedinger was not contractually required to accept the in-network discounts to claims for services. App. 34a. The District Court found that United's computer system grouped and down-coded procedures at inappropriate times, and it also suspended many claims improperly, requested unnecessary information before processing a claim, and denied claims without proper cause. App. 36a, 37a.

At the close of Petitioners' case-in-chief, the District Court granted a portion of Defendant's Motion for Judgment as a Matter of Law, and dismissed Count VII of the Second Amended Complaint, which constituted Petitioners' claims under civil RICO, "because Plaintiffs did not rely on the misstatements" made by Defendant in its EOBs. App. 58a.

After appeal was taken, and immediately prior to oral argument before the Circuit Court, this Court handed down the *Bridge* decision, which affirmed Petitioners' contention that "a plaintiff asserting a RICO claim predicated on mail fraud need not show, either as an element of its claim or as a prerequisite to establishing proximate causation, that it relied on the defendant's alleged misrepresentation." *Bridge*, 128 S.Ct. at 2145.

The Circuit Court, however, did not reverse the dismissal by the District Court on the civil RICO claim or remand for further proceedings in light of the *Bridge* decision. In failing to do so, the reported opinion of the Circuit Court will only confuse the law of civil RICO in the Eighth Circuit and its sister circuits and act to preclude aggrieved health care providers from bringing causes of action under civil RICO for the intentional and wanton conduct of health care insurers which systematically seek to undercut reimbursement for services provided.

Further, the Circuit Court asserted that United's EOBs contained only truthful statements. This is incorrect and misunderstands the express findings of the District Court. Such an assertion reflects that the Circuit Court failed to review all

orders of the District Court pertaining to the conduct of United. A reading of all orders issued by the District Court clearly demonstrates that it found that United's EOBs were in fact false and misleading.

The Circuit Court ignored the findings of fact which the District Court made after hearing *all* of the evidence:

> United's claims processing system was flawed in many ways, denying, reducing, and improperly processing claims on a regular basis.

App. 37a. The District Court further found:

> At trial, Plaintiffs provided *evidence* of Defendant's wanton behavior – United continuously processed claims improperly, long after it was made aware of its mistakes. Despite countless requests by Plaintiffs, Defendant refused to remedy its errors, at times owing up to $600,000 in past due fees. Defendant states that its mistakes were a result of computer error, not purposeful deception. However, it was within Defendant's power to remedy these errors. It chose not to.

App. 46a-47a (emphasis added). The District Court also found:

> . . . According to plaintiffs, however, United's computer system often inappropriately grouped and down coded, improperly suspended claims, unnecessarily requested additional information, and denied claims without proper cause. For

> example, plaintiffs claimed that United continued to classify (and pay) Schoedinger erroneously as an in-network provider after April 2005 (when he withdrew from the provider network).
>
> Although plaintiffs repeatedly complained to United about the inaccuracies and delays in claims processing, United did not change its claims processing or computer system and (at times) owed plaintiffs as much as several hundred thousand dollars in unpaid claims. According to plaintiffs, they created a separate office department just to notify United about and pursue errors and unpaid claims.

App. 18a-19a

The ruling of the Circuit Court is patently incorrect in both law and fact. The ramifications of its decision will curtail actions of health care providers seeking proper reimbursement for services provided. Further, the Circuit Court has in effect endorsed the improper practices of United, which presents an issue of grave concern to Petitioners as this conduct continues to this very day.

REASONS FOR GRANTING THE PETITION

Petitioners are entitled as a matter of law to the vacation of the decision of the Circuit Court as it pertains to civil RICO, and remand to the District Court for further proceedings in accordance with the *Bridge* opinion. Further, the Circuit Court misapprehended findings of fact of the District Court

which preclude a finding that the statements reflected in the EOBs were truthful.

By way of understanding the claims process used by United, the District Court accurately found:

> . . . A patient visits the healthcare provider (here Schoedinger) for services. The healthcare provider requests insurance information from the patient and receives an assignment of the patient's benefits. The assignment of benefits allows the healthcare provider to recover directly from the insurance company (here United, either as the insurer or the administrator and claims processor) for services rendered and, if necessary, to bring suit to obtain past-due benefits. After providing services, the healthcare provider submits a claim to the insurance company for payment. United requires providers to accurately designate services provided using numerical codes (CPT) developed by the American Medical Association.

App. 17a-18a. See also App. 34a-35a. After processing, discussed below, United mailed both payment and a corresponding EOB to the healthcare provider. App. 57a-58a.

The thrust of the civil RICO claim before the District Court was that United's computer system was (a) designed to improperly process the healthcare reimbursement codes submitted by Petitioners to Defendant and (b) mislead the healthcare provider through the use of misstatements on United's EOBs. The District Court found that United engaged in "down

coding" (reading certain healthcare reimbursement codes as requests for reimbursement for a less expensive service) and "bundling" or "grouping" (combining certain codes together as if they were one procedure). App. 36a, 37a. In addition, the District Court found that United continuously reduced Dr. Schoedinger's rates, as if he were an in-network provider. App. 36a, 37a. As an out-of-network provider, Dr. Schoedinger was not contractually required to accept in-network discounts to claims for services. The District Court found that United's computer system grouped and down-coded procedures at inappropriate times, and it also suspended many claims improperly, requested unnecessary information before processing a claim, and denied claims without proper cause. App. 36a, 37a.

Because of these deceptive practices, the Circuit Court correctly found that ". . . Signature incurred the expense of a claims department to ferret out and correct repeated errors that United refused to correct." App. 2a. It was *only* by the formation of this department that Petitioners were able to identify the deceptive practices employed by United in its claims processing. Petitioners compared the misrepresentations of United set forth in the EOBs against Petitioners' own records. Once an error had been identified by Petitioners' department, Petitioners attempted seek proper reimbursement through United's appeal process. Regardless, full payment was not made. This process ultimately resulted in the instant litigation (originally for reimbursements which had been unpaid for years and which totaled in excess of $600,000) to receive payments for claims which had

been persistently, intentionally, and improperly denied by United.

This Petition for Writ of Certiorari is necessitated because the Circuit Court, contrary to the findings of the District Court, concluded that United's EOBs were "truthful disclosures of discounts applied in determining what covered benefits United was paying." App. 12a. That was not a finding of the District Court and was not the basis for the District Court's judgment as a matter of law against Petitioners on the civil RICO claim. The District Court held that because there was no *reliance*, under the precedent existing in the Eighth Circuit at that time, no civil RICO claim could lie. App. 58a. Subsequently, the *Bridge* decision resolved that issue in Petitioners' favor so as to permit a civil RICO claim on such facts. It is now abundantly clear that the predicate act of mail or wire fraud in a civil RICO action does *not* require "reliance." It is enough that defendant *intended* to deceive, whether or not it succeeded. *See* 18 U.S.C. § 1341; *Neder v. United States*, 527 U.S. 1, 24-25, 119 S.Ct. 1827, 144 L.Ed.2d 35 (1999).

In failing to reverse, however, the Circuit Court cited language of the District Court which was deprived of context and bottomed on an understanding of civil RICO which was expressly overruled by this Court. The Circuit Court further made itself a finder of fact in making a determination not consistent with the District Court. Vacation of the opinion of the Circuit Court as to the issue of civil RICO, or the consideration of the merits of this matter, is required to ensure uniformity of the circuits is maintained and the future

civil RICO cases are not precluded due to the improper application of fact and law in this matter.

I. Whether the Circuit Court failed to follow the recent precedent in *Bridge v. Phoenix Bond & Indem. Co.*, 128 S.Ct. 2131, 170 L.Ed.2d 1012, 553 U.S. --- (2008) and reverse and remand the denial of Petitioners' cause of action under civil RICO due to Petitioners' failure to rely upon the misrepresentations of Defendant.

As to the first point presented for review, the Circuit Court provided only cursory analysis of the *Bridge* opinion, and has clearly failed to follow its teachings. The District Court relied upon pre-*Bridge* opinions of the Eighth Circuit[1] and dismissed Petitioners' civil RICO claim against United. The District Court expressly and specifically held that "[b]ecause Plaintiffs did not rely on [United's] misstatements, they do not have standing to bring a RICO action where the predicate act is wire or mail fraud." App. 58a.

Immediately prior to oral arguments before the Circuit Court, this Court handed down its decision in *Bridge*. This Court held that "a plaintiff asserting a RICO claim predicated on mail fraud need not show, either as an element of its claim or as a prerequisite to establishing proximate causation, that it relied on the defendant's alleged misrepresentations." *Bridge*, 128 S.Ct. at 2145. In so holding, this Court resolved the conflict between the circuits in which some circuits had

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[1] See, e.g., *Appletree Square I, Ltd. Partnership v. W.R. Grace & Co.*, 29 F.3d 1283, 1287 (8th Cir. 1994).

required proof of reliance in a civil RICO claim. In its decision, this Court noted that a first-party reliance requirement finds no support in RICO's text, nor did common law rules and policy require such first-party reliance. *Id.* at 2139. "After *Bridge*, plaintiffs need not plead or prove that they relied on defendants' alleged misrepresentations in order to establish the elements of their civil RICO claim based on mail or wire fraud. Dismissal of plaintiffs['] claims on this basis cannot be sustained." *Brown v. Cassens Transport Co.*, 546 F.3d 347, 357 (6th Cir. 2008).

In light of *Bridge*, other Circuit Courts have vacated a judgment against the plaintiff on the basis of failure to rely upon misrepresentations and have remanded cases to the district courts for further proceedings. See, e.g., *Chaz Concrete Co., LLC v. Codell*, 545 F.3d 407 (6th Cir. 2008); *Grange Mutual Casualty Co. v. Mack*, 290 Fed. Appx. 832 (6th Cir. 2008); *Brown v. Cassens Transport Co.*, 546 F.3d 347 (6th Cir. 2008). This is because the precedent relied upon was no longer viable. See *Codell*, 545 F.3d at 409. This instant case is indistinguishable and should be similarly treated.

Rather than reversing the District Court's order and judgment on this issue,[2] however, the Circuit Court affirmed the District Court's reliance upon non-viable precedent. In so doing, the Circuit Court breathes new

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[2] Plaintiffs appealed the judgment of the District Court in favor of Defendant on issues pertaining to breach of contract (Counts I and V), preemption of the Missouri Prompt Pay Act, Mo. Rev. Stat. § 376.383, *et seq.*, by ERISA (Count II), and injunctive relief (Count VI), which were also affirmed by the Circuit Court. These issues are not the subject of this Petition for Writ of Certiorari.

life into reasoning of those very decisions which this Court overruled in *Bridge*. See, e.g., *Appletree Square I, Ltd. Partnership v. W.R. Grace & Co.*, 29 F.3d 1283, 1287 (8th Cir. 1994), and its progeny. The opinion of the Circuit Court will serve to restrict civil RICO actions, and will effectively bar a health care provider from bringing a claim against a health care insurer such as United. Such a result is unconscionable especially in an instance where, as here, the willful, wanton, and systematic actions of United continue. See, e.g., App. 27a.

Petitioners request that this Court vacate the opinion of the Circuit Court to the extent that it affirmed the dismissal of their civil RICO claim for lack of reliance upon United's false and misleading statements.

II. Whether the Circuit Court failed to review all orders of the District Court as amended which reflect that the EOBs generated by defendant were false and misleading.

As to the second question presented for review, the Circuit Court relied upon findings of the District Court stripped of context and made prior to the close of all evidence. The Circuit Court held that any statements made by United in its EOBs were "truthful disclosures of discounts applied in determining what covered benefits United was paying." App. 58a. This is a gross misstatement of the totality of the findings of the District Court, and further, ignores the system created by United to conduct a scheme of persistent and pervasive underpayment of health care providers such as United.

In support of its decision, the Circuit Court relied upon Fed. R. Civ. P. 52(c) to assert that the Order dismissing Petitioners' civil RICO action was based upon partial findings of the District Court. See App. 11a-12a. The Circuit Court failed, however, to consider (a) *all* findings of the District Court in that order and (b) the *successive* findings of fact made by the District Court after the close of all evidence. A review of all findings of the District Court clearly demonstrates that the conduct of United was found to be intentional, improper, and false. Further, the cause of action asserted by Petitioners established that United's *program* caused the harm. App. 18a.

The EOBs were not truthful. However, the Circuit Court, in holding that a truthful EOB would preclude a civil RICO action, misconstrues the precedent of this Court. For example, in *Schmuck v. United States*, this Court held that even "'innocent' mailings - ones that contain no false information - may supply the mailing element" of a mail or wire fraud claim. 489 U.S. 705, 109 S.Ct. 1443 (1989) (citing *Parr v. United States*, 363 U.S. 370, 390, 80 S.Ct. 1171, 1183, 4 L.Ed.2d 1277 (1960)). This Court has further made clear that the elements of mail fraud are satisfied even where the mailings have been routine. See, e.g., *Carpenter v. United States*, 484 U.S. 19, 28, 108 S.Ct. 316, 322, 98 L.Ed.2d 275 (1987). Accordingly, that the Circuit Court mistakenly believed that the EOBs were truthful does not bar Petitioners from proceeding under civil RICO.

That was not, however, the finding of the District Court. The Circuit Court erred in misunderstanding the EOBs and holding that the

District Court's findings indicated that United properly disclosed its errors. Initially, Petitioners note that the passage upon which the Circuit Court relied in the District Court's Order was written *prior* to the close of all evidence. See App. 56a-58a. Further, the Order upon which the opinion relies conveys a much different meaning when read in its *entirety*:

> . . . The witnesses described *misstatements* on the Explanations of Benefits (EOB), which were mailed to Plaintiffs along with payment. In calculating payments made to Dr. Schoedinger, Defendant incorrectly took discounts, and improperly reduced the amount owed to the doctor through "down coding" and "bundling." Defendant's actions, although improper, were clearly explained on the EOB's.

App. 57a-58a (emphasis added). Merriam-Webster's OnLine Dictionary defines "misstatement" as "to state incorrectly : give a false account of." The District Court found in its May 22, 2006 Order that United's EOBs gave a "false account."

As the District Court explained in the very next paragraph:

> Signature Health Services has a department that engages in claim review. These employees review EOB's and compare them with the services performed by physicians to ensure accurate payment by insurance companies. After hearing testimony by Plaintiffs' witnesses, it is clear that these employees did not rely on the *faulty statements*

> made in the EOB's. They checked each EOB against their own records, never assuming that the discounts taken by Defendant were correct.

App. 58a (emphasis added). The District Court found in its May 22, 2006 Order that the EOBs contained misstatements and were *false*. The Circuit Court erred in finding that the EOBs were truthful.

Further, the Circuit Court ignores subsequent orders of the District Court on precisely same issue. The May 22, 2006 Order was interlocutory in nature as it did not dispose of all claims and parties. Fed. R. Civ. P. 54(b). Accordingly, the District Court had the jurisdiction to *amend* findings in its May 22, 2006 Order in its subsequent decisions. *Metzger v. UNUM Life Ins. Co. of America*, 476 F.3d 1161, 1165 (10 Cir. 2007). See also *Lindsey v. Dayton-Hudson Corp.*, 592 F.2d 1118, 1121 (10th Cir. 1979) ("Until final decree the court always retains jurisdiction to modify or rescind a prior interlocutory order."). When fewer than all claims are resolved, the district "court may direct the entry of a final judgment as to one or more" claims or parties, but in the absence of such a direction, any other form of decision "which adjudicates fewer than all the claims . . . is subject to revision at any time before the entry of [final] judgment." *K.C.1986 Ltd. Partnership v. Reade Mfg.*, 472 F.3d 1009, 1017 (8th Cir. 2007). The district court has the inherent power to reconsider and modify an interlocutory order any time prior to the entry of judgment. *United States v. State of Ark.*, 791 F.2d 1573, 1576-77 (8th Cir. 1986); *Persyn v. United States*, 935 F.2d 69, 74-75 (5th Cir. 1991); *Reinholdson v. Minnesota*, 346 F.3d 847, 851 (8th Cir. 2003).

The subsequent orders clarify the District Court's findings with regard to the EOBs. After the close of all evidence, the District Court found that:

> United's claims processing system was flawed in many ways, denying, reducing, and improperly processing claims on a regular basis.

App. 37a. The District Court further found:

> At trial, *Plaintiffs provided evidence of Defendant's wanton behavior* – United continuously processed claims improperly, long after it was made aware of its mistakes. Despite countless requests by Plaintiffs, Defendant refused to remedy its errors, at times owing up to $600,000 in past due fees. Defendant states that its mistakes were a result of computer error, not purposeful deception. However, it was within Defendant's power to remedy these errors. It chose not to.

App. 46a-47a (emphasis added).

> The District Court also found:
>
> . . . According to plaintiffs, however, United's computer system often inappropriately grouped and down coded, improperly suspended claims, unnecessarily requested additional information, and denied claims without proper cause. For example, plaintiffs claimed that United continued to classify (and pay) Schoedinger erroneously as an in-network provider after

> April 2005 (when he withdrew from the provider network).
>
> Although plaintiffs repeatedly complained to United about the inaccuracies and delays in claims processing, United did not change its claims processing or computer system and (at times) owed plaintiffs as much as several hundred thousand dollars in unpaid claims. According to plaintiffs, they created a separate office department just to notify United about and pursue errors and unpaid claims.

App. 18a-19a.

The District Court believed that United engaged in "wanton behavior." App. 21a, 46a. The District Court found that United's actions were "wrongful." App. 27a. The District Court ruled that United was culpable and acted in bad faith. App. 46a-47a. The District Court awarded Petitioners' attorneys' fees because United "failed to pay claims without reasonable cause." App. 20a. Further, the District Court sought to incentivize accurate claims administration and processing through its award of attorneys' fees and interest on Petitioners' ERISA claim. App. 47a. The behavior which the District Court sought to curtail (misleading processing and delinquent payments) continues to this day not only by United, but other healthcare insurers as well, victimizing health care providers nationally.

United's EOBs were misleading and were intended by United to be relied upon by Petitioners. Petitioners were forced to investigate each code on the

EOB and check it against its own internal records to identify instances in which United down-coded, bundled, grouped and/or paid Dr. Schoedinger for an in-network rate. These misstatements were *not* "clearly explained" as the Circuit Court concluded. These misstatements were evident only after the laborious process of investigation by Petitioners was conducted.

It is nonsensical for the Panel to act as a finder of fact and hold that the EOBs "truthfully" or "clearly" explained anything. Just because Petitioners did not *believe* United's EOBs does not bar or preclude it from pursuing a civil RICO action. That is the precise holding of *Bridge*. The clarity of *Bridge* is precisely what will be jeopardized should the Circuit Court's opinion be permitted to stand.

The error of the Circuit Court sets a precedent, contrary to *Bridge*, for those who have been mislead by healthcare insurers, an issue of national public importance. Due to broad and unsupported findings of fact of the Circuit Court, healthcare providers will be prevented from pursuing civil RICO actions against healthcare insurers. As it currently stands, physicians are either (a) not paid for the services they provide or (b) payment, if ever made, is delayed by months, and even years. This behavior damages the entire healthcare system. Indeed, the District Court noted that though United was the most egregious offender, it was not the only insurance company to deny, reduce and improperly process healthcare claims. *See* App. 37a.

CONCLUSION

For the foregoing reasons, the Court should grant the petition for writ of certiorari and reverse and vacate the opinion of the Circuit Court as it pertains to the issue of civil RICO. In the alternative, the Court should grant the petition for writ of certiorari, consider this case on the merits, and reverse and vacate the opinion of the Circuit Court.

Respectfully submitted,

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July 16, 2009

(any footnotes trail end of each document)

No. 07-3317

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

George Schoedinger; Signature Health Services, Inc.,
Plaintiffs - Appellants,

v.

United Healthcare of the Midwest, Inc.,
Defendant - Appellee.

June 11, 2008, Submitted
March 5, 2009, Filed

Appeal from the United States District Court for the Eastern District of Missouri.

Before LOKEN, Chief Judge, COLLOTON, Circuit Judge, and PIERSOL, * District Judge.

LOKEN, Chief Judge.

Orthopedic surgeon George Schoedinger and his employer, Signature Health Services, Inc. (collectively, "Plaintiffs"), commenced this action for damages and equitable relief, alleging that United Healthcare of the Midwest, Inc. ("United"), wrongfully denied or reduced 295 health care insurance claims. United removed the action because 289 of those claims were submitted under employee welfare benefit plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 et seq. Plaintiffs then filed an amended complaint asserting, as relevant here, state law claims for breach of contract and for violations of the Missouri Prompt Payment Act, Mo. Rev. Stat. §

376.383 ("MPPA"), and federal claims under ERISA and the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1964(c).

Prior to trial, United paid the unpaid principal amount of most of the claims. The evidence at the bench trial established that United's computerized claims processing system committed hundreds of errors that resulted in improper denial, reduction, or delayed payment of claims for Dr. Schoedinger's health care services. The errors included continuing to apply in-network discounts after Dr. Schoedinger terminated his provider agreement; inappropriate "grouping" or "bundling" of distinct medical procedures; improper "downcoding" (basing payment on a less expensive procedure); and requesting unnecessary information before processing claims. The result, Signature witnesses testified, was that United was consistently $200,000 to $600,000 delinquent in paying claims, and Signature incurred the expense of a claims department to ferret out and correct repeated errors that United refused to correct. After trial, the district court n1 awarded Plaintiffs an additional $28,874.04 in principal on the 289 ERISA claims, $4,768.62 in interest on the six non-ERISA claims, and $284,261.47 in pre-judgment interest, attorneys' fees, and costs. This award is not challenged on appeal. The court also dismissed the RICO claim at the close of Plaintiffs' case, and ruled at the close of all the evidence that United breached no independent contract governing the ERISA claims, that ERISA preempts claims for additional penalties under the MPPA, and that Plaintiffs are not entitled to broad injunctive relief. Plaintiffs appeal these rulings. We affirm.

I. The Breach of Contract Issue

Dr. Schoedinger is one of more than fifty physicians employed by Signature, one of the largest health care provider organizations in the St. Louis metropolitan area. United is a nation-wide health care insurer and claims administrator. Each year, Signature submits thousands of claims to United for treatment provided to patients covered by a health care plan administered by United. Before a patient covered by a United plan is treated by Dr. Schoedinger or another Signature physician, the patient signs an assignment of plan benefits form that Signature later submits to United with its claim for payment.

United's claim submission procedures are described on its website and in an administrative guide distributed to providers. Like most plan administrators, United maintains a network of participating providers who agree by written contract to accept, as full payment for services provided to patients covered by a United plan, an agreed amount that is typically lower than the billed charges. Dr. Schoedinger terminated his "in-network" agreement with United effective April 15, 2003. The claims at issue in this case were for patient treatment after that date, when Dr. Schoedinger was an "out-of-network" provider. Most Signature physicians remained in United's provider network. United's claim procedures appear to be the same for in-network and out-of-network providers.

At trial, United conceded that the patients' assignments of plan benefits provided a contractual basis for the ERISA and non-ERISA claims at issue. But Plaintiffs argued that the claims procedures

published by United on its website, in the administrative guide, and in insurance cards distributed to plan participants constituted an offer of an independent contract in which United promised to properly and promptly compensate Dr. Schoedinger every time he treated a United plan member. Finding no Missouri law addressing the issue in this context, the district court logically looked to Missouri cases determining whether an employee handbook created a contract between employer and employee. See *Johnson v. McDonnell Douglas Corp.*, 745 S.W.2d 661, 662 (Mo. banc 1988). The court found that none of United's documents "contain language which could be interpreted as a manifestation of willingness to enter into a bargain." Thus, there was no offer and no contract.

After careful review of the record, we conclude that the court's findings of no offer and no contract are not clearly erroneous. See *Kansas City Power & Light Co. v. Burlington N. R.R.*, 707 F.2d 1002, 1003 (8th Cir. 1983) (standard of review). At trial, Dr. Schoedinger testified that he had contracts with patients, not with United. United's website explains how to verify a patient's eligibility and submit health care claims, provides tips for faster claims processing, and describes how health care coverage decisions are made. A provider using the website who wishes to review United's reimbursement policy is first brought to a webpage entitled "Reimbursement Policy Agreement" which states that the policy "is intended to serve only as a general reference resource," and that United "may modify this reimbursement policy from time to time." The viewer must click, "I Agree," to then review detailed policies regarding matters such as "Co-Surgeon

Services" and "Multiple Procedure Reductions." Though more detailed than the website, we agree with the district court that United's administrative guide is an instruction manual, not a contract offer. The insurance cards United provides to plan beneficiaries expressly state, "This card does not prove membership nor guarantee coverage."

II. The MPPA Preemption Issue

The Missouri Prompt Payment Act imposes statutory penalties on a health carrier that "fails to pay, deny or suspend" a claim within forty days, and interest of one percent per month if the health carrier "has not paid the claimant on or before the forty-fifth day." Mo. Rev. Stat. §§ 376.383.5-.6. The district court awarded Plaintiffs interest for United's violations of these MPPA provisions in processing the six non-ERISA claims. However, the court denied MPPA relief on the 289 ERISA claims, concluding that these MPPA remedies are preempted by ERISA. Plaintiffs appeal that ruling, which we review *de novo*. *Painter v. Golden Rule Ins.* Co., 121 F.3d 436, 438 (8th Cir. 1997), cert. denied, 523 U.S. 1074, 118 S. Ct. 1516, 140 L. Ed. 2d 669 (1998).

ERISA preempts state laws that conflict with its provisions or frustrate its objectives. *Boggs v. Boggs*, 520 U.S. 833, 841, 117 S. Ct. 1754, 138 L. Ed. 2d 45 (1997). The Supreme Court has repeatedly held that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Aetna Health*

Inc. v. Davila, 542 U.S. 200, 208-09, 214-16, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004); see *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 52-54, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987). In *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194-95 (8th Cir. 1988), we held that ERISA preempts claims for penalties under the Missouri Vexatious Refusal to Pay Statute, Mo. Rev. Stat. § 375.420, explaining that "Pilot Life could not have stated with any greater clarity that the remedies afforded under ERISA are exclusive, and no state law purporting to supply additional remedies will escape the preemptive effect of [29 U.S.C.] § 1144(a)." We have consistently applied this principle. See *Werdehausen v. Benicorp Ins. Co.*, 487 F.3d 660, 669 (8th Cir. 2007) ("any state law remedy is preempted by ERISA's comprehensive remedial scheme") (emphasis omitted).

Plaintiffs argue that a state law obligating an ERISA plan administrator to promptly pay health care providers is not preempted because its impact on the plan is "too remote." Plaintiffs rely on the decision in *Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield*, 331 F. Supp. 2d 502, 511-12 (N.D. Tex. 2004), that the Texas Prompt Pay Law was not completely preempted by ERISA. We are not persuaded. Unlike the Texas statutes at issue in Baylor, the MPPA regulates health carrier payments to "claimants," who are broadly defined to include ERISA participants and beneficiaries. Mo. Rev. Stat. § 376.383.1(1). Moreover, the state law claim in Baylor was based on a provider agreement, whereas Dr. Schoedinger's ERISA claims are based on patients' assignments of plan benefits. Thus, the impact of the MPPA on plan administration is not "remote." Indeed, even if a provider asserts a contract right independent of his right under the

patient's assignment of plan benefits, the impact of additional state law remedies on ERISA plan administration may require preemption of a state law claim based on that contract. Cf. In *Home Health, Inc. v. Prudential Ins. Co. of Am.*, 101 F.3d 600, 606 (8th Cir. 1996); *Ark. Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1348-49 (8th Cir. 1991). Finally, the Baylor court's analysis of complete preemption seems inconsistent with the Supreme Court's later decision in Davila, which reversed a Fifth Circuit ruling that another claim under Texas law was not preempted.

For these reasons, we affirm the district court's ruling that ERISA preempts Plaintiffs' claims for MPPA remedies. We note that the district court's award of interest for wrongfully delayed ERISA benefit payments in this case was appropriate under 29 U.S.C. § 1132(a)(3)(B). *Parke v. First Reliance Standard Life Ins. Co.*, 368 F.3d 999, 1009 (8th Cir. 2004).

III. The RICO Claim

RICO prohibits a person associated with an "enterprise" from conducting the enterprise's affairs "through a pattern of racketeering activity" and provides a private right of action for treble damages to any person "injured in his business or property by reason of a violation." 18 U.S.C. §§ 1962(c), 1964(c). "Racketeering activity" is defined in § 1961(1)(B) to include "any act which is indictable" under the federal statute prohibiting mail fraud. A person is guilty of criminal mail fraud if he devises a "scheme or artifice to defraud" and uses the mails "for the purpose of executing such scheme or artifice." 18 U.S.C. § 1341.

An understanding of Plaintiffs' RICO claim requires additional background facts. The vast majority of the claims at issue (268 of 295) involved patients of Dr. Schoedinger who were railroad employees or dependents covered under ERISA health plans self-funded by the railroad employers. United processed these claims under separate contracts with the plans. The self-funded plans were liable for the benefits United paid, and United's compensation did not vary depending upon whether a claim for provider services was paid in full, reduced, or denied. When United processed a claim submitted by a provider that United considered an in-network provider -- whether correctly or incorrectly -- United as plan administrator acted unilaterally in determining applicable discounts and other coverage issues. However, when United processed a claim for services by an out-of-network provider, United's contracts with the railroad health care plans required that it submit the claim to Coalition America, Inc. ("Coalition").

Coalition was a competitor of United that contracted with the plans to "rent" additional provider networks and make those networks available to the plans, allowing the plans to receive discounted rates for services by providers not in United's network. It is undisputed that United's contracts with the plans required United to pay benefit claims based on "re-pricing" information it received from Coalition, that the plans paid Coalition a fee based on the savings obtained, and that Coalition otherwise played no role in United's actions as claims administrator.

After processing a health care claim, United sent Signature a computer-generated explanation of benefit

form ("EOB") along with any approved payment. United's errors in processing the 295 claims at issue were reflected in its initial EOBs to Signature. United's EOBs advised when United applied an out-of-network discount based on information received from Coalition, identified the "rented" provider network under which the discount was applied, and advised Signature to contact Coalition to challenge the discount, a process fraught with delays and unsatisfactory responses according to Signature's trial witnesses. Plaintiffs' RICO claim is premised on the assertions that United "engaged in a scheme to avoid paying full amounts of claims," that United's claims processing errors were intentional, and therefore that the erroneous EOBs constituted repeated acts of indictable mail fraud.

At the close of Plaintiffs' evidence, the district court granted United's motion for partial judgment dismissing this RICO claim. The district court ruled orally that United's motion for judgment was granted because Plaintiffs failed to provide "sufficient factual evidence to support the RICO claim." In a Memorandum and Order filed some days after trial, the court adopted United's argument that Plaintiffs lacked standing to assert a RICO claim under *Appletree Square I, LP v. W.R. Grace & Co.*, 29 F.3d 1283, 1286 (8th Cir. 1994), where we stated: "In order to establish injury to business or property 'by reason of' a predicate act of mail or wire fraud, a plaintiff must establish detrimental reliance on the alleged fraudulent acts." While the case was pending on appeal, the Supreme Court resolved a conflict in the circuits on this issue, holding that "a plaintiff asserting a RICO claim predicated on mail fraud need not show, either as an element of its claim or as a prerequisite to establishing

proximate causation, that it relied on the defendant's alleged misrepresentations." *Bridge v. Phoenix Bond & Indem. Co.*, 128 S. Ct. 2131, 2145, 170 L. Ed. 2d 1012 (2008). Therefore, Plaintiffs argue, the dismissal of this claim must be reversed.

Plaintiffs argue that we review the RICO claim dismissal under the standard applicable to the grant of judgment as a matter of law, resolving all fact conflicts in their favor and giving them the benefit of all reasonable inferences. This is incorrect. The district court granted judgment on partial findings at the close of the Plaintiffs' case in a bench trial, a procedure expressly authorized by Rule 52(c) of the Federal Rules of Civil Procedure. "[A]n appellate court that reviews a judgment made on partial findings may not set aside the findings of fact unless they are clearly erroneous, i.e., a review of the evidence leaves the court with a firm belief that a mistake has been made." 9 Moore's Federal Practice § 52.52[1] (2008). When Rule 52(c) was amended in 2007 to delete a prior reference to judgment as a matter of law, the Advisory Committee notes explained: "The standards that govern judgment as a matter of law in a jury case have no bearing on a decision under Rule 52(c)."

Plaintiffs further argue on appeal that *they* are entitled to judgment on their RICO claim and a new trial on damages. But that would not be the appropriate remedy given our substantial doubt whether Plaintiffs' proof at trial established other elements of a RICO damage action the district court did not address. First, it is undisputed that United as plan administrator acted unilaterally in determining discounts such as grouping and downcoding and in incorrectly treating Dr.

Schoedinger as an in-network provider after April 15, 2003. Thus, as to these claims, Plaintiffs apparently failed to prove what every circuit has required to establish a RICO damage claim under 18 U.S.C. § 1962(c) -- that United, the RICO defendant, was distinct from the alleged enterprise whose affairs were allegedly conducted through a pattern of racketeering activity. See *Fogie v. Thorn Americas, Inc.*, 190 F.3d 889, 896-97 (8th Cir. 1999), and cases cited; *United States v. Goldin Ind., Inc.*, 219 F.3d 1268, 1271 (11th Cir. 2000) (en banc).

Second, the participation of the plans and Coalition in the processing of claims where Dr. Schoedinger was treated as an out-of-network provider raises the possibility of an "association-in-fact" enterprise distinct from United. But the plans, who established independent contractual relations with United and Coalition and reaped the financial benefit of any cost savings, are not accused of misconduct. Nor was there evidence United and Coalition acted in unison. These facts suggest a finding that Plaintiffs failed to prove that United had "some part in directing [the enterprise's] affair." *Dahlgren v. First Nat'l Bank of Holdrege*, 533 F.3d 681, 689 (8th Cir. 2008), cert. denied, 129 S. Ct. 1041, 2009 WL 160646 (U.S. 2009), quoting *Reves v. Ernst & Young*, 507 U.S. 170, 179, 113 S. Ct. 1163, 122 L. Ed. 2d 525 (1993).

We do not decide those issues because they were not the subject of the findings of fact and conclusions of law that Rule 52(c) requires. Returning to the issue the district court did decide, the court's conclusion that lack of detrimental reliance was, by itself, fatal to Plaintiffs' RICO claim was overruled by the subsequent decision

in Bridge. But that conclusion was supported by findings that are not clearly erroneous:

> In calculating payments made to Dr. Schoedinger, [United] incorrectly took discounts, and improperly reduced the amount owed to the doctor through "down coding" and "bundling." *[United's] actions, although improper, were clearly explained on the EOB's.*

(Emphasis added.) While a plaintiff's detrimental reliance is not an element of a RICO claim predicated on mail fraud, "materiality of falsehood is an element of the federal mail fraud, wire fraud, and bank fraud statutes." *Neder v. United States*, 527 U.S. 1, 25, 119 S. Ct. 1827, 144 L. Ed. 2d 35 (1999); see *United States v. Goodman*, 984 F.2d 235, 237 (8th Cir. 1993) (a scheme to defraud must be "reasonably calculated to deceive persons of ordinary prudence and comprehension"). In this case, the only allegedly material falsehoods claimed by Plaintiffs were the incorrect EOBs. But as the district court found, the EOBs were what they purported to be -- truthful disclosures of discounts applied in determining what covered benefits United was paying. Plaintiffs concede that the EOBs clearly explained United's justifications for the underpayments.

It is not a scheme to defraud to adopt as a claims policy, "When in doubt, apply the discount and truthfully disclose it." It might be fraud to intentionally (or with reckless disregard) apply and disclose deductions known to be improper when the claims payer knows that a substantial number of claimants would not challenge the deductions. But Plaintiffs' proof at trial

(to the extent made part of the record on appeal) included no evidence of such intentional deceit, only repeated, unexplained errors. And there is no proper basis to assume such intentional fraud, which if uncovered would destroy United's credibility as an ERISA plan fiduciary. Nor did Plaintiffs present evidence that the railroad health plans devised a scheme to intentionally underpay providers and enlisted United to implement that scheme with inaccurate EOBs. For these reasons, although the district court's legal conclusion regarding reliance was undercut by Bridge, we affirm the dismissal of the RICO claim because the trial record and the court's findings "sufficiently inform[this] court of the basis for the trial court's decision." *Scoggins v. Board of Educ.*, 853 F.2d 1472, 1477 (8th Cir. 1988) (quotation omitted).

IV. Injunctive Relief

Finally, Plaintiffs contend that the district court erred in declining to enter a proposed twenty-one-paragraph injunction detailing the manner in which United must process future claims. Plaintiffs contend they are entitled to injunctive relief under state law, without disclosing whether the injunction they seek would be limited to non-ERISA claims and, if not, why ERISA would not preempt such relief. Treating this as an issue of state law, the district court denied the requested injunction because (i) the court "is not in the insurance business, and will not impose such exacting restrictions upon a corporate entity," and (ii) Plaintiffs have an adequate remedy "provided through ERISA and state law." Reviewing this decision for abuse of discretion under both ERISA and state law, we affirm. See *Hinz v. Neuroscience, Inc.*, 538 F.3d 979, 986 (8th Cir. 2008),

and *State ex rel. Ellis v. Creech*, 364 Mo. 92, 259 S.W.2d 372, 374 (Mo. banc 1953) (of review). As the district court noted, ERISA allows for the recovery of costs and attorneys fees in addition to unpaid plan benefits.

The judgment of the district court is affirmed.

Footnote

*The HONORABLE LAWRENCE L. PIERSOL, United States District Judge for the District of South Dakota, sitting by designation.

1The HONORABLE STEPHEN N. LIMBAUGH, SR., United States District Judge for the Eastern District of Missouri, now retired.

Case No. 4:07-CV-00664 SNL

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI,
EASTERN DIVISION

GEORGE SCHOEDINGER, M.D., and SIGNATURE HEALTH SERVICES, INC.,
Plaintiffs,

vs.

UNITED HEALTHCARE OF THE MIDWEST, INC.,
Defendant.

Filed August 31, 2007

JUDGMENT

It has been brought to the attention of the Court that certain orders pursuant to Memorandum Opinions have been entered without the entry of a formal judgment pursuant to Rule 58.

IT IS THEREFORE ORDERED that plaintiff shall have judgment against the defendant as follows:

1. $28,874.04 for principal on the 289 ERISA benefit claims and $4,768.62 for interest on the 6 non-ERISA benefit claims pursuant to the Court's November 6, 2006 memorandum (#91); plus

2. Pre-judgment interest, attorney's fees and costs in the sum of $284,261.47 pursuant to the Court's opinion of August 28, 2007 (#110) for a total of $317,904.13.

Case No. 4:07-CV-00664 SNL

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI,
EASTERN DIVISION

GEORGE SCHOEDINGER, M.D., and SIGNATURE HEALTH SERVICES, INC.,
Plaintiffs,

vs.

UNITED HEALTHCARE OF THE MIDWEST, INC.,
Defendant.

August 28, 2007, Decided
August 28, 2007, Filed

JUDGES: Stephen N. Limbaugh, SENIOR UNITED STATES DISTRICT JUDGE.

MEMORANDUM OPINION

The Court requested the parties to submit supplemental briefs on attorney's fees and costs, and prejudgment interest. For the reasons discussed below, the Court awards plaintiffs attorney's fees and costs, and prejudgment interest as follows:

Statement of the Case

The following statement of the case is taken in large part from the Memorandum and Order entered on November 6, 2006 (# 91-1). Plaintiffs George Schoedinger, M.D. and Signature Health Services, Inc.,

initially filed this action in state court to recover monies owed to them by United Healthcare of the Midwest, Inc. (United) for improperly processed healthcare claims. United removed the case to the federal district court, and a bench trial was conducted in May 2006.

Signature Health Services, Inc. (Signature) is a Missouri corporation with its principal place of business in St. Louis, Missouri, and employs Schoedinger, an orthopedic surgeon who lives and practices in St. Louis. Signature bills and collects payment on Schoedinger's behalf for services he provides to his patients who are (in the present case) participants or beneficiaries of health plans insured or administered by United. United is a Missouri Corporation and a wholly-owned subsidiary of UnitedHealthcare Services, Inc., a wholly-owned subsidiary of UnitedHealth Group, Inc. United both administers health plans and provides health insurance.

Schoedinger was a participating provider in United's network of providers. In-network providers are paid discounted rates for services; out-of-network providers are paid undiscounted rates. On April 15, 2005, Schoedinger terminated this network agreement. From that date there was no written contract between Schoedinger and United, and United patients were charged full price (and Schoedinger should have been paid undiscounted rates for services provided). Schoedinger continued to treat United patients and submit claims to United for payment.

As noted in the memorandum and order, the healthcare claims process is quite complicated. A patient visits a healthcare provider (here Schoedinger) for services.

The healthcare provider requests insurance information from the patient and receives an assignment of the patient's benefits. The assignment of benefits allows the healthcare provider to recover directly from the insurance company (here United, either as the insurer or the administrator and claims processor) for services rendered and, if necessary, to bring suit to obtain past-due benefits. After providing services, the healthcare provider submits a claim to the insurance company for payment. United requires healthcare providers to accurately designate services provided using numerical codes (CPT) developed by the American Medical Association.

United uses a computer system to process claims. The computer system is programmed to reduce costs (where appropriate) by "down coding" (reading certain CPT codes as requests for a less expensive service) and "grouping" (combining certain CPT codes as if they were a single procedure). Down coding and grouping are industry practices. According to plaintiffs, however, United's computer system often inappropriately grouped and down coded, improperly suspended claims, unnecessarily requested additional information, and denied claims without proper cause. For example, plaintiffs claimed that United continued to classify (and pay) Schoedinger erroneously as an in-network provider after April 2005 (when he withdrew from the provider network).

Although plaintiffs repeatedly complained to United about the inaccuracies and delays in claims processing, United did not change its claims processing or computer system and (at times) owed plaintiffs as much as several hundred thousand dollars in unpaid claims.

According to plaintiffs, they created a separate office department just to notify United about and pursue errors and unpaid claims.

In April 2004 plaintiffs (understandably frustrated) filed a lawsuit against United in state court, seeking payment of its claims for services on state law grounds. United removed the case to federal district court on the ground that the Employee Retirement Income Security Act of 19784 (ERISA), 29 U.S.C. § 1144(a), completely preempted state law, insofar as state law related to any employee benefit plan (health insurance). In the second amended complaint, plaintiffs claimed breach of contract (count I), violation of the Missouri Payment of Claims statute (count II), unjust enrichment (count III), vexatious refusal to pay (count IV), sought declaratory judgment (that there is a contract between the parties and that United breached that contract by failing to pay claims promptly and properly) (count V) and injunctive relief (count VI), civil RICO violations (count VII), and sought payment under ERISA for benefits due (29 U.S.C. § 1132(a)(1)(B)) (count VIII), and for breach of fiduciary duty (29 U.S.C. § 1132(a)(3) (count IX).

Of the 295 claims at issue in the case, 289 involved employee welfare plans under ERISA, and 6 involved non-ERISA plans. Of the 289 ERISA claims, 268 involved self-funded or self-insured plans, for which United served only as the plan administrator and claims processor (the employers are financially responsible for benefits). The other 21 ERISA claims and the 6 non-ERISA claims involved plans insured by United. For these 27 claims, United is responsible for

benefits and also serves as the plan administrator and claims processor.

The Court dismissed the civil RICO count. Memorandum and Order at 1 (# 83) (count VII).

United did not contest that a contract existed for the 6 non-ERISA plan claims (for which plaintiffs had an assignment of rights from the patients) and conceded that it breached its contract with these patients. Following a bench trial, the Court found that for the 289 ERISA claims, there was no contract between Schoedinger and United under state law on the basis of the employee handbook, the on-line plan documents or the plan administrative guide, and so there was no claim for breach of contract or declaratory judgment. *Id.* at 8-9 (counts I and V). The Court found ERISA preempted the Missouri Prompt Pay Act and other state law with respect to the 289 ERISA plan claims. *Id.* at 12-13 (count II (in part)). Before trial, plaintiffs acknowledged that counts III (unjust enrichment) and IV (vexatious refusal to pay) were preempted by ERISA). The Court found that United failed to promptly pay the 6 non-ERISA claims and awarded damages in the amount of $6,208.62. *Id.* at 13 (part of count II). The Court also awarded plaintiffs reasonable attorney's fees because United failed to pay the claims without reasonable cause. *Id.* 13-14.

United did not dispute plaintiffs' right to recover on the 289 ERISA claims, and the parties agreed that the principal amount due for those claims is $28,874.04. *Id.* at 14 (count VIII). The Court awarded plaintiffs prejudgment interest at the rate of 5.07%, pursuant to 28 U.S.C. § 1961(a). Memorandum and order at 14 (rate

equal to weekly average one-year constant maturity Treasury yield, which the Court identified as "currently 5.07%"). The Court also awarded plaintiffs reasonable attorney's fees and costs pursuant to 29 U.S.C. § 1132(g)(1) (ERISA authorizes a court "in its discretion" to allow a reasonable attorney's fee and costs of action to either party). Memorandum and Order at 15-16. "Although an award of attorney's fees is not mandatory, there is a presumption that a prevailing plan beneficiary [here the healthcare provider] should recover reasonable attorney's fees unless 'special circumstances' would make such an award inequitable." *Emmenegger v. Bull Moose Tube Co.*, 33 F. Supp. 2d 1127, 1131 (E.D. Mo. 1998) (citation omitted).

The Court considered the five factors listed in case law when making this decision. *Id.* at 15, *citing Starr v. Metro Systems, Inc.*, 461 F.3d 1036, 1041 (8th Cir. 2006). The court noted that plaintiffs had provided evidence of United's wanton behavior. Memorandum and Order at 15 ("United continuously processed claims improperly, long after it was made aware of its mistakes. Despite countless requests by [p]laintiffs, [United] refused to remedy its errors. . . ."). The Court noted that United could afford to pay attorney's fees. *Id.* The Court decided that an award of attorney's fees might have a future deterrent effect under similar circumstances. *Id.* The Court noted that plaintiffs sought only to benefit themselves, not all participants and beneficiaries of an ERISA plan; however, the Court noted that the lawsuit did raise a new issue, whether the Missouri Prompt Payment Act was preempted by ERISA, an issue which the Court characterized as "arguably significant." *Id.* at 16 (ERISA preemption is a challenging issue). Finally, the Court considered the relative merits of the

parties' claims, noting that plaintiffs were entitled to recover on the ERISA claims and some of the state law claims. *Id.*

The Court denied injunctive relief. *Id.* at 17 (count VI). Accordingly, of the counts in the second amended complaint, plaintiffs prevailed under ERISA with respect to the 289 ERISA plan claims (count VIII) and under the Missouri Prompt Payment Act for the 6 non-ERISA claims (part of count II), but did not prevail on their state law breach of contract claims (count I), the Missouri Prompt Payment Act with respect to the 289 ERISA claims (most of count II), unjust enrichment (count III), vexatious refusal to pay (count IV), declaratory judgment (count V), injunctive relief (count VI), or breach of fiduciary duty under ERISA (count IX). Nonetheless, although plaintiffs were not successful on most of their state law theories for relief or on their civil RICO count (for example, because their state law counts were preempted or failed to state a claim under RICO), they did recover their unpaid claims, with some minor adjustments.

Pre-Judgment Interest

The parties do not dispute that plaintiff is entitled to pre-judgment interest, but do differ as to the calculation of the amount.

In the Court's order of November 6, 2006 pre-judgment interest was granted plaintiff on $28,874.04 representing plaintiff's right to recover on 289 ERISA claims. (The amount was inaccurately calculated as $28,287.04 on page 18 of the order). The order provided

that the interest was to be calculated at 5.07%. 28 U.S.C. § 1961.

Defendant paid 281 claims before trial, and eight were disputed at trial. Plaintiff claims he should receive $38,195.50 interest on 283 claims and $16,754.69 interest on the disputed claims or $54,950.19. He also requests interest of $17.75 per day from November 7, 2006 through December 21, 2006 and $18.63 per day from January 1, 2007 to the date of final judgment. (Plaintiff's response to defendant's supplemental brief, p. 4). This is pre-judgment interest "compounded annually" through the date of judgment. *Burch v. Hartford Life & Acc. Ins. Co.*, 383 F. Supp. 2d 1119 (W.D. Ark. 2005).

Defendant calculates the amount as $25,389.07 plus $6.08 per day from November 18, 2006 to the date of judgment. (Defendant's response to plaintiff's brief in support of pre-judgment interest, p. 6).

Although the Court is uncertain as to plaintiff's precise calculation of the $54,950.19 interest claimed; it is obviously far in excess of the 5.07% granted. Accordingly, defendant's assessment more clearly meets the Court's original order and the statute, 28 U.S.C. § 1961.

The Court will therefore award pre-judgment interest as follows:

1. Interest at 5.07% to November 17, 2006	$25.389.07
2. Interest at 6.08% per day from November 18,	$1,732.80

2006 to August 28, 2007	
(285 days @ $6.08)	
Total	$27,121.87

Attorney's Fees & Costs

Reduction for Limited Success

United next argues the Court should greatly reduce the award of attorney's fees and costs for limited or partial success. United argues that "the vast majority of such fees and costs were incurred during [p]laintiffs' prosecution of entirely unsuccessful causes of action." Defendant's supplemental brief at 2. United argues plaintiffs did not prevail on the request for declaratory judgment (as to the existence of a contract between the parties), for statutory penalties under the Missouri Prompt Payment Act (for the 289 ERISA claims), for civil RICO violations, and for injunctive relief. United argues that these unsuccessful causes of action took up much of the discovery and trial. United notes that before trial it conceded that it owed plaintiffs for the ERISA claims and the non-ERISA claims and the amounts (and even paid the ERISA claims for the most part).

United argues that plaintiffs unnecessarily complicated what were simple ERISA claims to recover benefits (the ERISA claims) and simple contract claims (the non-ERISA claims), especially since United conceded what it owed plaintiffs before trial. United argues that most of the discovery and much of the briefing and trial involved plaintiffs' unsuccessful causes of action or

theories for relief, especially the state law claims preempted by ERISA and the civil RICO claims.

Plaintiffs agree that before trial United paid the ERISA claims but not the non-ERISA claims. Plaintiffs argue that although the non-ERISA claims were few in number compared with the ERISA claims, they prevailed on all of them. Plaintiffs characterize this as "an unmitigated success." Plaintiffs' response to defendant's supplemental brief at 5. Plaintiffs further argue that they were forced to investigate and litigate this case solely because of United's "wanton behavior." *Id.* Plaintiffs also argue that a reduction for limited success is not warranted because the unsuccessful and successful claims were factually and legally interrelated and because the vigorous litigation of all the claims, including the unsuccessful ones contributed to the overall, successful outcome and should not result in a reduction for limited success. *Id.* Plaintiffs argue that their attorney's fees, at their standard hourly rate, is $362,123.70, plus costs and expenses, $15,723.71. Plaintiffs' memorandum in support at 10.

Other reductions

Plaintiffs also argue that no reduction for "billing judgment" is required. Plaintiffs argue that counsel submitted invoices that were sufficiently detailed in terms of time and tasks performed. Plaintiffs also argue that the Court should allow the cost of computerized legal research as part of the award of reasonable attorney's fees. Plaintiffs also argue that the Court should determine the lodestar rate using the market rate and not the actual rate billed to the client, which, counsel argues, was a discounted rate. Plaintiffs note

that the case required extensive discovery and analysis and research of novel and challenging questions involving federal and state law.

Plaintiffs also request costs and expenses incurred by managed care specialist Nancy Glass in investigating and preparing for litigation ($78,393.99).

Settlement Offer

United also argues that the Court should not award plaintiffs any attorney's fees and costs after April 27, 2006, the date when United made a substantial settlement offer. United argues that plaintiffs did not recover after trial more than this substantial offer. United argues that it offered plaintiffs what it owed on the ERISA and non-ERISA claims, interest (calculated at 12%) and $50,000 in attorney's fees. United also argues that plaintiffs attended a court-ordered mediation proceeding in September 2005, but were not prepared to participate in good faith. United does not expressly argue that its offer was a valid offer under Fed.R.Civ.P. 68, but argues that the Court can consider substantial settlement offers in determining an award of reasonable attorney's fees. United argues that this case should not have gone to trial. In United's view, this case involved essentially simple contract claims which plaintiffs needlessly complicated with meritless claims for declaratory judgment, injunctive relief, statutory penalties and civil RICO claims.

Plaintiffs argue that when viewed in context, United did not make a substantial settlement offer. Plaintiffs argue that United insisted on mediation before completion of discovery, that plaintiffs objected on the

ground that mediation was premature, and that plaintiffs agreed to participate in mediation after discovery. Plaintiffs argue that, at the first mediation session, United made no offer. Plaintiffs argue that even though United knew that plaintiffs strongly believed that an injunction was necessary (to correct the computerized processing of claims), United did not offer any assurances about correcting the mishandling of claims. Plaintiffs argue that, even after litigation of this case, United has not changed it computer system and that plaintiffs are even now owed more than $200,000 in unpaid claims.

Plaintiffs remind the Court that this litigation was caused solely by what the Court has already described as the wrongful conduct of United. Plaintiffs note that they were compelled to spend considerable time and money reviewing nearly three hundred claims and investigating and preparing for trial. Plaintiffs also argue that the settlement offer did not comply with Fed.R.Civ.P. 68 (although without specifying exactly how the offer was deficient). Plaintiffs' response to defendant's supplemental brief at 9. Plaintiffs argue that the Court may still award attorney's fees even if a settlement offer is rejected.

The general principles for determining an award of attorney's fees are well-known. "[W]here a plaintiff's claims for relief involve a common core of facts or are based on related legal theories, a court determining an appropriate fee award 'should focus on the significance of the overall relief obtained . . . in relation to the hours reasonably expended on the litigation.'" *Emmenegger v. Bull Moose Tube Co.*, 33 F. Supp.2d at 1140, *citing Hensley v. Eckerhart*, 461 U.S. 424, 435, 103 S. Ct. 1933,

76 L. Ed. 2d 40 (1983). Here, the claims for relief involved a common core of facts. The Court notes that the litigation involved considerable time and effort in understanding healthcare claims processing. In addition, some of the legal theories were related. For example, ERISA and the Missouri Prompt Payment Act and the various state law contract theories were related. However, the same cannot be said of the civil RICO claim, which required considerable time and effort (and no doubt caused much anxiety to defend).

Plaintiffs were very successful to the extent that they recovered the unpaid claims. They were less successful in terms of the legal theories they advanced; they recovered under ERISA (and the Missouri Prompt Payment Act on the non-ERISA claims), but lost on preemption (because ERISA preempted most of their state law claims) and failed to state a civil RICO claim. These were significant and difficult legal issues, particularly at the time this litigation began several years ago. The Court believes that a one-third reduction reflects this limited degree of success.

The Court has considered the settlement offer made by defendant and that plaintiffs recovered less than the monetary elements of the settlement offer. However, the Court finds that plaintiffs reasonably rejected the settlement offer for non-monetary reasons (which were not part of the settlement offer) because they believed that injunctive relief was crucial (plaintiffs sought to correct the claims processing process) (and even though injunctive relief was ultimately denied).

The Court agrees that the hourly rate should be the standard hourly rate and not the discounted hourly

rate. The relevant hourly rate is the market rate (considering such factors as expertise, experience, locale) and not the rate to which counsel and the client agreed. *See e.g., Central States, Southeast & Southwest Areas Pension Fund v. Central Cartage Co.*, 76 F.3d 114, 115, 116 (7th Cir.), *cert. denied*, 519 U.S. 811, 117 S. Ct. 56, 136 L. Ed. 2d 19 (1996); *cf. Blum v. Stenson*, 465 U.S. 886, 104 S. Ct. 1541, 79 L. Ed. 2d 891 (1984) (litigant represented by nonprofit legal aid society could recover fees computed at market rate for similar legal work).

Without considering a precise exercise of calculating attorney time devoted to unsuccessful requests made by plaintiff, the Court finds a substantial amount of work was spent on those requests. While some of the work on different items may have been interrelated to the successful endeavors of plaintiff's counsel, nevertheless, there should be a deduction for the attorney time spent in the unsuccessful areas. Accordingly, the Court will deduct $120,707.90 from the attorney's fee request of $362,123.70 and award an attorney's fee of $ 241,415.80.

The Court will award costs (pursuant to Fed.R.Civ.P. 54, 28 U.S.C. § 1920) and expenses in the sum of $15,723.71, but denies the expenses claimed for Nancy Glass. The Court does not deny that Ms. Glass's assistance was helpful in the preparation and litigation of the case, however, she is not an attorney, legal assistant or law clerk. Even though Glass testified for plaintiff he has presented no authority permitting him to recover fees charged by an outside expert. *Ryther v. Kare*, 864 F. Supp. 1525. *See also Patton, et al. v. Simon Property Group, Inc., et al., slip copy*, 2007 U.S. Dist.

LEXIS 57064, 2007 W.L. 2236732 (E.D. Ark.) (costs of experts in preparation of exhibits is denied).

Conclusion

The Court therefore finds that plaintiffs should recover from defendant the following amounts:

1. Pre-Judgment Interest	$27,121.87
2. Attorney's Fees	$241,415.89
3. Costs	$15,723.71
Total	$284,261.47

Dated this 28th day of August, 2007.
[Signature]
SENIOR UNITED STATES DISTRICT JUDGE

Case No. 4:07-CV-00904 SNL

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI,
EASTERN DIVISION

GEORGE SCHOEDINGER, M.D., and SIGNATURE HEALTH SERVICES, INC.,
Plaintiffs,

vs.

UNITED HEALTHCARE OF THE MIDWEST, INC.,
Defendant.

November 6, 2006, Decided
November 6, 2006, Filed

SUBSEQUENT HISTORY: Costs and fees proceeding at Schoedinger v. United Healthcare of the Midwest, Inc., 2007 U.S. Dist. LEXIS 63565 (E.D. Mo., Aug. 28, 2007)
Affirmed by Schoedinger v. United Healthcare of the Midwest, Inc., 557 F.3d 872, 2009 U.S. App. LEXIS 5063 (8th Cir. Mo., 2009)

PRIOR HISTORY: Schoedinger v. United Healthcare, 2006 U.S. Dist. LEXIS 32012 (E.D. Mo., May 22, 2006)

CORE TERMS: patient, attorney fees, provider, healthcare, processing, healthcare provider, reimbursement, pre-empted, claimant, carrier, notice, state law, prompt payment, benefit plan, online, injunctive relief, plan participants, adequate remedy, notification, in-network, employee handbook, cause of

action, prejudgment interest, documentation, injunction, suspend, unpaid, law claims, breach of contract, opposing party

COUNSEL: For George Schoedinger, Signature Health Services, Inc., Plaintiffs: Stefan J. Glynias, Kevin L. Fritz, LASHLY AND BAER, P.C., St. Louis, MO.

For United Healthcare of the Midwest, Inc., Defendant: Allen D. Allred, Jeffrey R. Fink, THOMPSON COBURN, St. Louis, MO.

JUDGES: Stephen N. Limbaugh, SENIOR UNITED STATES DISTRICT JUDGE.

OPINION BY: Stephen N. Limbaugh

OPINION

MEMORANDUM AND ORDER

Plaintiffs George Schoedinger and Signature Health Services have filed this action in law and equity, seeking to recover monies owed to them by Defendant United Healthcare for improperly processed healthcare claims. The Court held a non-jury trial on May 16 through 17, 2006. During that trial, the Court granted a portion of Defendant's Motion for Judgment as a Matter of Law, and dismissed Plaintiffs' RICO claims for failure to state a *prima facie* case. In addition, Plaintiffs ceased pursuing their claims for Unjust Enrichment and Vexation Refusal, conceding that they were preempted by ERISA. The central remaining issues are: (1) whether the Employee Retirement

Income Security Act (ERISA) pre-empts Plaintiffs' state law claims; (2) whether a contract existed between the parties; (3) whether Defendant violated the Missouri Prompt Payment Act (MMPA); and (4) whether Plaintiffs are entitled to injunctive relief. This matter is now ripe for disposition.

After careful consideration of all objections to exhibits and testimony taken with the case, all but one of said objections are hereby overruled, and all but one of the exhibits offered into evidence at the trial are received into evidence. Defendant's objection regarding Plaintiffs' Exhibit 178 is sustained for failure to comply with Rule 26(a) of the Federal Rules of Civil Procedure and Rule 1006 of the Federal Rules of Evidence. All testimony will be considered by the Court and given its due weight. This Court, having now considered the pleadings, the testimony of witnesses, documents in evidence, and any other evidentiary materials submitted for the Court's consideration, and being fully advised in the premises, hereby makes the following findings of fact and conclusions of law as required by Rule 52 of the Federal Rules of Civil Procedure.

FINDINGS OF FACT [1]

Plaintiff Signature Health Services (Signature) is a Missouri corporation with its principal place of business in St. Louis, Missouri. Signature employs physicians in a wide array of medical fields. One of those physicians is Plaintiff George Schoedinger (Schoedinger), an orthopedic surgeon who resides in St. Louis, Missouri. As part of the Plaintiffs' business relationship, Signature is authorized to bill and collect payment on

Schoedinger's behalf for the services he provides to his patients.

Defendant United HealthCare of the Midwest (United), is a Missouri corporation and a wholly owned subsidiary of UnitedHealthcare, Inc., which is a wholly-owned subsidiary of United HealthCare Services, Inc., which is a wholly-owned subsidiary of UnitedHealth Group Incorporated. United is in the business of administering health plans and providing health insurance.

Schoedinger was a participating provider in United's network. Under this agreement, patients covered by United healthcare plans were given reduced rates. But on April 15, 2003, Schoedinger terminated this agreement. From that date forward, there was no written contract between Schoedinger and United, and United's patients were charged full price for services rendered. Nevertheless, Schoedinger continued to treat United's patients and submit claims to United for payment.

The healthcare claims process is quite complicated. Initially, a patient visits a healthcare provider like Plaintiffs for treatment. Plaintiffs request insurance information from the patients, and then receive an assignment of the patients' benefits. [2] After treating the patient, Plaintiffs submit their claim to United for payment. United requires that healthcare providers follow certain procedures when submitting these claims. These requirements are set forth on United's website and in an Administrative Guide distributed to providers.

The Administrative Guide is approximately thirty pages long, and describes how to contact United, the claims process, how to read a customer identification card, United's product line, notification requirements for planned procedures, requirements for network providers, and guidelines for treating medicare patients. In a preamble before describing the claims process, the Administrative Guide states: "We know that you want to be paid promptly for the services you provide. Here's what you can do to help promote prompt payment." Pl's Ex. 165, at 3. The Guide then directs healthcare providers to register on United's website, review a customer's eligibility before providing services, notify United of any planned procedures, prepare a complete and accurate claim form using the proper Current Procedural Terminology (CPT), [3] and submit these claims electronically. *Id.* United also sets forth detailed guidelines for the notification of planned procedures, listing which procedures and services require prior notification, what sort of explanation is required, and how and when the notification is to be made. These guidelines note that "[t]his notification list may change from time to time," but that United would provide notice prior to any changes. *Id.* at 10. The notification guidelines further state that the "list does not signify coverage for benefits. Coverage is determined by the customer's benefit contract." *Id.* at 14.

United's online documentation also explains the company's policies and procedures. United provides "some basic information about working with [the company]" on a page entitled "UnitedHealthcare Policies." Pl's Ex. 162. This webpage informs healthcare providers how to verify a patient's eligibility and send

claims for payment, provides tips for faster claims processing, and describes how healthcare coverage decisions are made. *Id.* The United website also contains a page entitled "Reimbursement Policy Agreement." Pl's Ex. 163. The documents states that healthcare providers "are responsible for [the] submission of accurate claims requests," that the "reimbursement policy is intended to ensure that [providers] are reimbursed based on the [CPT] code that correctly describes the procedure performed," and that the "reimbursement policy applies to all professionals who deliver health care services." *Id.* The webpage further states that "[t]his information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation." *Id.* And United notes that it "may modify this reimbursement policy from time to time by publishing a new version of the policy on [its] [w]ebsite." *Id.*

After a healthcare provider submits a claim for payment, United uses an automated computer system to process the claim. This computer system is designed to reduce the cost of healthcare claims through practices such as "down coding" (reading certain codes as requests for reimbursement for a less expensive service) and "grouping" (combining certain codes together as if they were one procedure). Down coding and grouping are industry practices, and are often warranted. However, United's computer system often grouped and down coded procedures at inappropriate times. The computer system also suspended many claims improperly, requested unnecessary information before processing a claim, and denied claims without

proper cause. In addition, United continuously charged Schoedinger reduced rates, as if he were an in-network provider. [4]

United's claims processing system was flawed in many ways, denying, reducing, and improperly processing claims on a regular basis. And despite innumerable requests, United was unwilling to remedy the underlying errors in its systems. United was consistently delinquent in paying claims, the amount past due ranging from $200,000 to $600,000 at any given time. And United's faulty processing of claims continued even after Plaintiffs filed suit.

United is not the only insurance company to make such errors. But in Plaintiffs' practice, United is the most egregious offender. In response, Signature created a department to verify processed claims. This department contacted United on a continuous basis, notifying United of its errors, and attempting to help the insurance company fix those problems. The claims department routinely phoned or emailed United about every unpaid claim, and continued to contact United until each claim was properly paid.

Plaintiffs lawsuit centers around 295 claims for services rendered by Schoedinger to patients covered by United healthcare plans. 289 of these claims qualify as Employee Welfare Benefit Plans under ERISA, and 6 involve non-ERISA plans. [5] 268 of the ERISA claims surround self-funded or self-insured health plans, in which the employers are financially liable for any benefits due and United serves only as the plan administrator and claims processor. 21 of the ERISA claims and all of the non-ERISA claims involve health

plans that are fully insured by United. For these 27 claims, United is financially responsible for the benefits due to plan participants and serves as the plan administrator and claims processor.

CONCLUSIONS OF LAW

I. Contract Claims

In Counts I and V of this cause of action, Plaintiffs request that the Court issue a declaratory judgment stating that there is a contract between the parties, and find that Defendant breached that contract by failing to pay claims promptly and properly. [6] Plaintiffs argue that the Defendant's online documentation and Administrative Guide constituted an open offer to healthcare providers, and that Plaintiffs accepted this offer by following Defendant's claims processing procedures and providing medical care to patients with United insurance.

The Court can find no law addressing this issue in an insurance scenario. However, Plaintiffs' argument is akin to whether an employee handbook creates a contract between employers and their employees. Therefore, the Court will take its guidance from Missouri common law examining the contractual effect of employee handbooks.

In Missouri, "employee handbooks generally are not considered contracts because they normally lack the traditional prerequisites of a contract." *McIntosh v. Tenet Health Sys. Hosps., Inc./Lutheran Med. Ctr.*, 48 S.W.3d 85, 89 (Mo. Ct. App. 2001). The case *Johnson v. McDonnell Douglas Corp.*, 745 S.W.2d 661 (Mo. 1988),

is the seminal case on this issue. In *Johnson*, an employee brought a claim of wrongful discharge against her employer, claiming that an employment contract formed when the employer distributed an employee manual. The Missouri Supreme Court found that an employer's "unilateral act of publishing its handbook [is] not a contractual offer to its employees." *Id.* at 662. Instead, it is "an informal statement of [the employer's] self-imposed policies." *Id.* The employee handbook in *Johnson* often employed general language, and noted that the rules were subject to change. Therefore, "a reasonable at will employee could not interpret its distribution as an offer to modify his at will status." *Id.* Because the employee handbook did not constitute an offer, no contract was formed.

Like in *Johnson*, United's online documents and Administrative Guide did not create a contract. Initially, neither set of documents contain language which could be interpreted as "a manifestation of willingness to enter into a bargain." Restatement (Second) of Contracts § 24 (1981). In addition, the documents contain generalized language and put the reader on notice that the claims procedures could change in the future. The online documents state that they contain "some basic information about working with us." Pl. Ex. 162. And that the "information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy." Pl. Ex. 163. Further, United noted that it might "modify this reimbursement policy from time to time by publishing a new version of the policy." *Id.* The Administrative Guide, although more detailed than the online documentation, is simply an instruction manual, nothing more.

A contract cannot form without an offer. Because Defendant's online documentation and Administrative Guide did not constitute an offer, there was no contract between Plaintiffs and Defendant. Without a contract, there can be no breach. *See Volker Court, LLC v. Santa Fe Apartments, LLC*, 130 S.W.3d 607, 611 (Mo. Ct. App. 2004). Therefore, Plaintiffs have not established their entitlement to relief for breach of contract and are not entitled to a declaratory judgment.

II. Missouri Prompt Payment Act

Plaintiffs next claim that Defendant's failure to promptly pay the 295 claims constituted a violation of the MMPA, Mo. Rev. Stat. § 376.383. Defendant claims that ERISA pre-empts the MMPA on 289 of the claims and that Plaintiffs failed to follow the requirements to state a claim under the MMPA. [7]

ERISA Pre-Emption

ERISA "supercede[s] any and all State laws insofar as they ... relate to any employee benefit plan." 29 U.S.C. § 1144(a). "A law 'relates to' an employee benefit plan ... if it has a connection with or reference to such a plan." *Id.* at 96-97. A state law may "relate to" and therefore be preempted even if the state law was not designed to affect benefit plans and its effect on such plans is incidental. *Johnston v. Paul Revere Life Ins.*, 241 F.3d 623, 630 (8th Cir. 2001). However, "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw v. Delta Airlines*, 463 U.S. 85, 100 n.21, 103 S.Ct. 2890, 77 L.Ed2d 490 (1983). To determine whether a state law

has a "connection with" an ERISA plan, the Court is directed to "look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as the nature of the effect of the state law on ERISA plans." *Parkman v. Prudential Ins. Co. of Am.*, 439 F.3d 767, 771 (8th Cir. 2006) (internal quotations omitted).

The main purpose of the ERISA pre-emption clause "was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995). Therefore, courts are "reluctant to tamper with [the] enforcement scheme embodied in the statute by extending remedies not specifically authorized by its text." *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 210, 122 S. Ct. 708, 151 L. Ed. 2d 635 (2002).

The law currently at issue is the Missouri Prompt Payment Act, Mo. Rev. Stat. § 376.383. Pursuant to the MPPA, if an insurer fails to pay, deny, or suspend a claim within a specified amount of time, a claimant is entitled to interest and penalties. A claimant is defined as "any individual, corporation, legal association, partnership or other legal entity asserting a right to payment ... under a health benefit plan." Mo. Rev. Stat. § 376.383.1(1).

Plaintiffs cite *Baylor Univ. Med. Ctr. v. Ark. Blue Cross Blue Shield*, 331 F. Supp. 2d 502, 511-12 (N.D. Tex. 2004), for the premise that prompt payment statutes are not pre-empted by ERISA. *Baylor*

examined a Texas statute that required insurance companies to pay the claims of physicians and other healthcare providers in a timely manner. The court found that the law impacted ERISA plans "only tenuously, remotely, or peripherally" and refused to "insulate an insurer from liability against a third-party health care provider seeking to enforce its rights under a state statute that requires prompt payment of claims." *Id.* at 511.

However, in *Baylor* the court examined a prompt payment statute that differed from Missouri's in one important respect -- the law did not apply to plan participants. In fact, the court rested its ruling upon this very issue:

> The substance of Baylor's statutory claims are governed by state laws that enforce the prompt payment of claims by insurers-not to plan participants or beneficiaries, but to independent health care providers. Nothing in ERISA prevents the Texas legislature from making this determination. By enforcing the Texas statutes at issue, plan participants' actual obligations under the terms of their various plans would remain constant and the plans' terms would be unmodified. Baylor's statutory claims, thus, do not directly affect the relationship between traditional ERISA entities.

Id. at 511-12. Because Missouri's law is applicable to plan participants and beneficiaries, the MPPA is pre-empted by ERISA. Enforcing the Missouri statute at issue would alter a plan participant's actual obligations under his or her plan.

"[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Aetna Heath Inc. v. Davila*, 542 U.S. 200, 210, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004). The MMPA allows any individual to bring a civil action and recover penalties if an insurance company does not pay claims in accordance with Missouri's standards. This has a substantial effect on ERISA plans, and is expressly pre-empted by 29 U.S.C. § 1144(a).. *See In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194 (8th Cir. 1998) (making a similar finding as to the Missouri vexation refusal statute). Therefore, the MMPA does not govern any actions involving the 289 ERISA claims.

Missouri Prompt Payment Act Requirements

The MMPA imposes penalties on health carriers that fail to process claims in a timely manner. There are two major penalty provisions in the statute. The first requires that a health carrier pay a claim within forty-five days of receipt of the claim, otherwise the health carrier must pay the claimant one percent interest per month on the unpaid balance of the claim. [8] Mo. Rev. Stat. § 376.383.5. The second provision is more involved. Initially, if a health carrier does not "pay, deny or suspend" an insurance claim within forty days of its receipt, and the healthcare provider notifies the carrier of this deficiency after the fortieth day, "the health carrier shall, in addition to monthly interest due, pay to the claimant per day an amount of fifty percent of the claim but not to exceed twenty dollars for failure to pay all or part of a claim or interest due thereon or deny or

suspend as required by this section." Mo. Rev. Stat. § 376.383.6. This first tier of penalties accrues for thirty days, and then ceases unless the claimant subsequently "provides a second written or electronic notice," informing the health carrier that the claim is unpaid and that the claimant will seek penalties under the MMPA. *Id.* If the claimant provides such notice, the penalty continues to accrue until the health carrier "pays, denies or suspends the claim" or the claimant files a petition to collect the penalties, whichever is sooner. *Id.*

The Plaintiffs have proven that Defendant did not pay, deny, or suspend the six non-ERISA claims within forty-five days of receiving the claim. Therefore, under the clear language of the MMPA, Plaintiffs are entitled to one percent monthly interest for the six unpaid or partially paid non-ERISA claims. This interest is to be calculated from the forty-fifth day after Defendant received notice of the claim up until the date of final payment. Through testimony, Plaintiffs also established that they consistently notified Defendant about the unpaid or partially paid claims, and worked with the Defendant on a regular basis to collect the funds due. Therefore, the Court finds that Plaintiffs notified Defendant about the deficiencies more that forty days after the claim was filed. Plaintiffs established their right to collect under the first tier of penalties in Section 376.383.6. This penalty accrues for thirty days, or until Defendant paid, denied, or suspended the claim, whichever was earlier. However, Plaintiffs have not established their right to penalties under the second tier of the statute. Although Plaintiffs often provided electronic notice of the delinquencies, this notice did not inform Defendant that Plaintiffs would seek penalties

under the MMPA. Therefore, Plaintiffs are not entitled to the second level of penalties set forth in Section 376.383.6. Accordingly, Plaintiffs may recover damages totaling $6,208.62 for Defendant's MMPA violations. [9] In addition, the Court finds that Defendant failed to pay these claims and penalties without reasonable cause, therefore Plaintiffs are entitled to "reasonable attorney fees for services necessary for recovery." Mo. Rev. Stat. § 376.383.6.

III. ERISA

In the alternative to their state law causes of action, Plaintiffs brought a claim for breach of contract and breach of fiduciary duty under 29 U.S.C. § 1132. Defendant does not dispute Plaintiffs' right to recover on the 289 ERISA claims, and both parties agree that the principal amount due is $28,874.04. The Court will also grant Plaintiffs' request for prejudgment interest. *See Kennedy v. Georgia-Pacific Corp.*, 31 F.3d 606, 611 (8th Cir. 1994) ("Awards of prejudgment interest are discretionary under ERISA); *Stroh Container Co. v. Delphi Indus., Inc.*, 783 F.2d 743, 752 (8th Cir. 1986) ("As a general rule, prejudgment interest is to be awarded when the amount of the underlying liability is reasonably capable of ascertainment and the relief granted would otherwise fall short of making the claimant whole because he or she has been denied the use of money which was legally due").

The prejudgment interest is to be determined in accordance with 28 U.S.C. § 1961. *Sheehan v. Guardian Life Ins. Co.*, 372 F.3d 962, 969 (8th Cir. 2004). The interest is to be calculated "at a rate equal to the weekly average 1-year constant maturity Treasury

yield," which is currently 5.07%. 28 U.S.C. § 1961. The interest accrues from the date Schoedinger performed the medical service through the date of final judgment. *Sheehan*, 372 F.3d at 969. However, the Court requires additional briefing before ruling upon the total amount of interest due.

Pursuant to 29 U.S.C. § 1132(g)(1), the Court has discretion to award reasonable attorney's fees and costs to either party. A prevailing plaintiff in an ERISA action "rarely fails to receive fees." *Starr v. Metro Sys., Inc.*, 461 F.3d 1036, 1041 (8th Cir. 2006). Courts are to examine five non-exclusive factors when making this determination:

> (1) the degree of culpability or bad faith of the opposing party; (2) the ability of the opposing party to pay attorney fees; (3) whether an award of attorney fees against the opposing party might have a future deterrent effect under similar circumstances; (4) whether the parties requesting attorney fees sought to benefit all participants and beneficiaries of a plan or to resolve a significant legal question regarding ERISA itself; and (5) the relative merits of the parties' positions.

Id.

At trial, Plaintiffs provided evidence of Defendant's wanton behavior -- United continuously processed claims improperly, long after it was made aware of its mistakes. Despite countless requests by Plaintiffs, Defendant refused to remedy its errors, at times owing up to $600,000 in past due fees. Defendant states that

its mistakes were a result of computer error, not purposeful deception. However, it was within Defendant's power to remedy these errors. It chose not to. Therefore, the Court finds that the first factor supports an award of attorney's fees.

As to the second factor, United is a large insurance company with vast resources. This factor also supports an award of attorney's fees.

With regard to the third factor -- whether an award of attorney fees against the opposing party might have a future deterrent effect under similar circumstances -- the Court finds that this also supports an award of attorney's fees. At trial, Schoedinger testified as to the damage done by insurance companies that improperly process claims on a regular basis. Whether it be purposeful or negligent, insurance companies regularly reduce and deny claims without cause, thereby increasing the cost of healthcare to providers and patients alike. If it became cost prohibitive for insurance companies to engage in this behavior, it would incentivize more accurate claims administration and processing in the future.

Plaintiffs' lawsuit sought to benefit only the Plaintiffs, not all participants and beneficiaries of an ERISA plan. The lawsuit did raise a new issue: whether the MMPA is superceded by ERISA. This legal question does involve ERISA itself, and is arguably significant. Therefore, the fourth factor tilts marginally in favor of an award of attorney's fees.

As to the final factor, the relative merits of the parties claims, the Court has found that Plaintiffs were entitled

to recover on their ERISA claims and some of their state law claims. Thus, the fifth factor also supports awarding Plaintiffs attorney's fees. Therefore, in accordance with the factors set forth in *Starr*, the Court finds that Plaintiffs are entitled to recover all reasonable attorney's fees and costs incurred in this action.

IV. Common Law Injunctive Relief

Lastly, Plaintiffs seek injunctive relief under Missouri law. [10] Pursuant to state statute, a plaintiff may obtain an injunction when "an irreparable injury to real or personal property is threatened, and to prevent the doing of any legal wrong whatever, whenever in the opinion of the court an adequate remedy cannot be afforded by an action for damages." Mo. Rev. Stat. § 526.030. Therefore, Plaintiffs must establish: (1) the likelihood of irreparable harm absent injunctive relief, and (2) the absence of an adequate remedy at law. *Kelly v. Golden*, 352 F.3d 344, 353 (8th Cir. 2003). Once a plaintiff makes this showing the Court may, in its discretion, grant an injunction.

In Plaintiffs proposed order for injunction, they suggest that this Court require that United follow Plaintiffs' suggested claims processing procedures. This Court is not in the insurance business, and will not impose such exacting restrictions upon a corporate entity.

In addition, Plaintiffs have an adequate remedy -- it is provided through ERISA and state law. *See Parke v. First Reliance Standard Life Ins. Co.*, 368 F.3d 999, 1005 (8th Cir. 2004) (patient with long-term disability could not seek injunction against insurance company

because ERISA created an adequate remedy at law). Plaintiffs claim that there is no adequate remedy because ERISA does not allow for the recovery of attorney's fees, thus Plaintiffs cannot be made whole through successive suits. Despite Plaintiffs' assertions, ERISA does allow a court to award reasonable fees and costs, and as stated above, the Court awarded such fees to Plaintiffs. Plaintiffs also claim that legal remedies are inadequate because of the time, energy, and resources Plaintiffs must spend to collect money from United. However, these complaints are insufficient for the Court to take such a drastic step. Therefore the Court declines to issue an injunction in this matter.

CONCLUSION

Plaintiffs' state law claim for breach of contract as to the 289 ERISA claims fails because there was no independent contract between the parties. Neither the Administrative Guide nor the online documentation contained any statements that could be construed as an offer to contract. Plaintiffs' sole remedy for the contractual breach is as an assignee of patients' benefits. As an assignee, Plaintiffs established their right to recover for breach of contract on the six non-ERISA claims. The remainder of Plaintiffs' breach of contract claims are pre-empted by ERISA. Because Defendant paid the principal amount owing on these six claims during the course of the litigation, any monetary recovery is limited to that provided under the MMPA. Plaintiffs' claims under the MMPA are also pre-empted by ERISA. The statute allows a patient to bring suit for an insurer's failure to pay benefits in a prompt manner, therefore the MMPA relates to ERISA and extends remedies that are not specifically authorized by

federal law. However, Plaintiffs have established their right to recover under the MMPA for the six non-ERISA claims, and are entitled to $6,208.62 in interest and penalties. Plaintiffs' rights under ERISA were never disputed, and they shall recover the principal amount due and owing on these claims, which is $28,287.04. Plaintiffs are also entitled to prejudgment interest and the reasonable attorney's fees and costs accrued in this action. Finally, the Court refuses Plaintiffs' petition for injunctive relief. Their requests are overly broad, and Plaintiffs have an adequate remedy at law. Therefore, equitable relief is not warranted.

Accordingly,

IT IS HEREBY ORDERED that Plaintiffs George Schoedinger and Signature Health Services shall have judgment against Defendant United Healthcare of the Midwest in the amount of $34,495.66.

IT IS FURTHER ORDERED that the parties shall submit supplemental briefs as to the amount of prejudgment interest and Plaintiffs' reasonable attorney's fees and costs on or before November 17, 2006.

Dated this 6th day of November, 2006.

Stephen N. Limbaugh
SENIOR UNITED STATES DISTRICT JUDGE

Footnotes

1 The Court's factual findings are derived from the parties' exhibits, witness testimony, and the parties' briefs. Where necessary, the Court will cite to specific evidence and/or testimony. Where more than one copy of the same exhibit has been filed by different parties, the Court will cite to only one exhibit; however, the reference should not be considered any indication of bias on the part of the Court.

2 The assignment of benefits allows the Plaintiffs to recover directly from the insurance company for services rendered, and if necessary, bring suit to obtain past due benefits. In general, if Plaintiffs did not receive an assignment of benefits, they would have no legal cause of action against an insurance company. Therefore, Plaintiffs would have to recover any past due funds directly from the patient, who could then bring suit against the insurance company to recover the benefits due.

3 Providers must designate the services performed using CPT, which is a uniform numerical code developed by the American Medical Association. Each medical service and procedure is given a unique code to allow for more streamlined claims processing.

4 This in-network problem was a result of United's relationship with Coalition America. Per its agreement with certain employers, United was required to send all claims to Coalition America before processing the claims. Coalition enters into agreements with various insurance companies to share network provider agreements. Therefore, if a doctor has an in-network agreement with one company, Coalition will apply that agreement to another insurance company, thereby

borrowing the in-network discount through a process called "re-pricing." Coalition America improperly listed Schoedinger as an in-network provider and consistently re-priced his claims. Plaintiffs contacted United about this problem many times. However, Coalition America did not remove Schoedinger from their in-network provider list, and United would not confirm the propriety of Coalition America's re-pricing before paying the claims. Therefore, a substantial percentage of Schoedinger's claims were improperly discounted, and no amount of notice or complaints could convince United to remedy this problem.

5 For additional findings of fact involving the six non-ERISA plans, see Attachment A.

6 Plaintiffs cause of action addresses two sets of claims -- those for the ERISA based claims and those for the non-ERISA claims. Defendant does not contest that a contract existed for the 6 non-ERISA plans, which stemmed from the patients' assignment of rights. Defendant concedes that it did breach its contract with these patients, and as an assignee, Plaintiffs may bring a cause of action for this breach. During the course of the litigation, Defendant paid the principal amount owing on these claims, and the interest due will be discussed below. However, as to the ERISA claims, Plaintiffs cannot bring a common law suit as an assignee because it would be pre-empted by ERISA. The remainder of this discussion focuses on whether Plaintiffs have a contract with Defendant, independent of the rights assigned to Plaintiffs by their patients.

7 Defendant also argues that the MMPA does not apply to the 268 self-funded benefit claims because Defendant

was not a "health carrier" within the meaning of the statute. As stated below, the Court finds that the MMPA is pre-empted by ERISA. Therefore the Court need not address this issue.

8 Section 376.383.6 specifies that the penalties are to end after the claim is paid, or upon the filing of a lawsuit. However, the Missouri legislature remained silent as to when the interest penalties are to stop. The Court interprets the legislature's silence as meaning that the interest penalties cease accruing when the amounts due are paid.

9 See Attachment A.

10 Because several of the claims at issue involve non-ERISA plans, Plaintiffs' common law claim for injunctive relief is not pre-empted by ERISA.

Claim #	Claim Filed	Amt Billed	Amt Paid	Delinquent Amt	Day 40	Day 45
		(in $)	(in $)	(in $)		
11007097	12/30/03	163	36.36	126.55	2/4/08	2/13/04
10927011	11/30/03	19201	2423.75	16777.25	1/9/04	1/14/04
12190341	9/15/04	514	91.32	422.68	10/25/04	10/30/04
12258371	9/15/04	1971	499.18	1471.82	10/25/04	10/30/04
12557561	12/16/04	21753	0	21753	1/25/05	1/30/05
11258491	04/04/05	30619	0	30619	5/15/04	5/15/04
Claim #	Del. Amt Pd	# of month	1% per month	# of days	$20 per day	Total
			(in $)		(in $)	(in $)
11007097	5/13/05	15	19	30	600	619
10927011	5/16/04	5	838.86	30	600	1438.86
12190341	11/05/04	1	4.23		n/a	4.23
12258371	11/05/04	1	4.72		n/a	14.72
12557561	2/18/05	1	217.53		n/a	217.53
11258491	5/5/09	12	3674.28	12	240	3914.28
			4768.62		1440	6208.62

See Plaintiffs' Exhibit 177 and Defendant's Exhibit A

The above represents the Court's calculation of damages under the MMPA. As required by the MMPA, all date calculations were made starting with the date Plaintiffs filed their claim with United. To determine monthly interest, the Court calculated the number of months between Day 45 and the date the Delinquent Amount was Paid. The Court then multiplied together the Delinquent Amount, Number of Months, and One Percent to calculate the total interest owed. To determine the daily penalty, the Court first determined that a fifty percent daily penalty would be greater than the twenty dollar daily penalty in all situations, and uniformly applied the twenty dollar penalty. The Court then determined the Number of Days by subtracting Day 40 from the date the Delinquent Amount was Paid or the date the lawsuit was filed (May 27, 2004), whichever was earlier. The Number of Days was capped at thirty, as required by statute. The Court then multiplied the Number of Days by twenty dollars to calculate the total penalty. Finally, three claims were not considered in the twenty dollar penalty calculation because the Plaintiffs filed these claims with United after bringing this lawsuit. Under the MMPA, the Plaintiffs cannot recover a twenty dollar daily penalty on these claims.

Case No. 4:07-CV-00904 SNL

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF MISSOURI,
EASTERN DIVISION

GEORGE SCHOEDINGER, M.D., and SIGNATURE HEALTH SERVICES, INC.,
Plaintiffs,

vs.

UNITED HEALTHCARE OF THE MIDWEST, INC.,
Defendant.

May 22, 2006, Decided

Stephen N. Limbaugh, SENIOR UNITED STATES DISTRICT JUDGE.

MEMORANDUM AND ORDER

Plaintiffs George Schoedinger and Signature Health Services brought suit against Defendant United Healthcare of the Midwest. Plaintiffs brought several claims against the Defendant, among them was a claim under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961 *et seq.* The case was heard by this Court on May 16-17, 2006. At the close of Plaintiffs' case, Defendant moved for judgment as a matter of law. The Court found that Plaintiffs failed to state a prima facie claim under RICO, and granted Defendant's request as to this Count. The Court issues this memorandum in support of its findings.

RICO "makes it 'unlawful for any person employed by or associated with any enterprise ... to conduct or participate ... in the conduct of such enterprise's affairs' through the commission of two or more statutorily defined crimes -- which RICO calls 'a pattern of racketeering activity.'" *Cedric Kushner Promotions, Ltd. v. King*, 533 U.S. 158, 160, 121 S. Ct. 2087, 150 L. Ed. 2d 198 (2001) (citing 18 U.S.C. § 1962(c)). Here, Plaintiffs alleged that Defendant engaged in wire and mail fraud, 18 U.S.C. § 1341, which is a statutorily defined predicate act under RICO. 18 U.S.C. § 1961(1)(B).

To have standing to bring a claim under RICO, a plaintiff must have been "injured in his business or property by reason of" a RICO violation. 18 U.S.C. § 1964(c). "The 'by reason of' language requires the plaintiff to demonstrate that the defendant's racketeering activity was the proximate cause of its injury." *Appletree Square I, Ltd. P'ship v. W.R. Grace & Co.*, 29 F.3d 1283, 1286 (8th Cir. 1994) (citing *Holmes v. Securities Inv. Prot. Corp.*, 503 U.S. 258, 265-66, 112 S. Ct. 1311, 117 L. Ed. 2d 532 (1992)). "In order to establish injury to business or property 'by reason of' a predicate act of mail or wire fraud, a plaintiff must establish detrimental reliance on the alleged fraudulent acts." *Id.* (citing *County of Suffolk v. Long Island Lighting Co.*, 907 F.2d 1295, 1311 (2d Cir. 1990); *Reynolds v. East Dyer Dev. Co.*, 882 F.2d 1249, 1253 (7th Cir. 1989); *Brandenburg v. Seidel*, 859 F.2d 1179, 1188 n. 10 (4th Cir. 1988)).

At trial, Plaintiffs complained that Defendant underpaid Dr. Schoedinger for services rendered to patients with United Healthcare insurance. The witnesses

described misstatements on the Explanations of Benefits (EOB), which were mailed to Plaintiffs along with payment. In calculating payments made to Dr. Schoedinger, Defendant incorrectly took discounts, and improperly reduced the amount owed to the doctor through "down coding" and "bundling." Defendant's actions, although improper, were clearly explained on the EOB's.

Signature Health Services has a department that engages in claim review. These employees review EOB's and compare them with the services performed by physicians to ensure accurate payment by insurance companies. After hearing testimony by Plaintiffs' witnesses, it is clear that these employees did not rely on the faulty statements made in the EOB's. They checked each EOB against their own records, never assuming that the discounts taken by Defendant were correct. Because Plaintiffs did not rely on the misstatements, they do not have standing to bring a RICO action where the predicate act is wire or mail fraud. Therefore, Count VII of Plaintiffs' Second Amended Complaint is dismissed.

Accordingly,

IT IS HEREBY ORDERED that Defendant's Motion for Judgment as a Matter of Law is GRANTED in part. Count VII of Plaintiff's Second Amended Complaint is DISMISSED.

Dated this 22nd day of May, 2006.

Stephen N. Limbaugh
SENIOR UNITED STATES DISTRICT JUDGE